# **Extent of invasion** (Core)

Surgical resection specimens should be assessed for depth of tumour invasion, as this is an independent prognostic factor. Invasion into the serosa is associated with peritoneal recurrence and poor prognosis.[1] Gastric cancer can directly invade into adjacent structures/organs, which include the spleen, transverse colon, liver, diaphragm, pancreas, abdominal wall, adrenal gland, kidney, small intestine and retroperitoneum.[2] Direct infiltration of the duodenum or oesophagus is not considered invasion into an adjacent organ.

The term 'carcinoma in situ' is not commonly applied to glandular epithelium. However, high grade dysplasia in a gastric resection specimen can be reported as 'carcinoma in situ' as recommended by the Union for International Cancer Control (UICC)[3]/ American Joint Committee on Cancer (AJCC)[2] 8th Edition Staging Systems mainly for tumour registry reporting purposes.

## References


1 Ludeman L and Shepherd NA (2005). Serosal involvement in gastrointestinal cancer: its assessment and significance. *Histopathology* 47(2):123-131.

2 Amin MB, Edge SB, Greene FL, Byrd DR, Brookland RK, Washington MK, Gershenwald JE, Compton CC, Hess KR, Sullivan DC, Jessup JM, Brierley JD, Gaspar LE, Schilsky RL, Balch CM, Winchester DP, Asare EA, Madera M, Gress DM and Meyer LR (eds) (2017). *AJCC Cancer Staging Manual. 8th Edition*, Springer, New York.

3 Brierley JD, Gospodarowicz MK and Wittekind C (eds) (2016). *Union for International Cancer Control. TNM Classification of Malignant Tumours, 8th Edition*, Wiley-Blackwell, USA.